Kansas Disease Investigation Guidelines

General Investigation Form

Investigation Information

Case Type: ☐Human Case ☐Non-human Case ***Disease Name:*** _____

Classification: ☐Suspect ☐Probable ☐Confirmed ***KS-EDSS Investigation ID:*** _____

Outbreak: ☐Yes ☐No ***Outbreak Name:*** _____ ***Outbreak #:*** _____

Onset Date: _____ ***Diagnosis Date:*** _____ ***Report Date:*** _____

Assigned to (Investigator): _____ ***Patient Died:*** ☐Yes ☐No ☐Unknown

Patient Information

Name Type: ☐Default/Common ☐Legal ☐Maiden ☐Nickname

Last: _____ ***First:*** _____ ***Middle:*** _____

Street: _____ ***City/State:*** _____ ***Zip:*** _____

Evening Phone #: _____ ***Daytime Phone #:*** _____

Sex: ☐Failure to Report ☐Female ☐Male ☐Other ☐Transexual ☐Unknown

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Unknown

Hispanic / Latino Ethnicity: ☐Yes ☐No

Date of Birth: _____ ***Age:*** _____ ***Age Unit:*** ☐Days ☐Weeks ☐Months ☐Years

Parent Information (if under 18)

Last: _____ ***First:*** _____ ***Middle:*** _____

Street: _____ ***City/State:*** _____ ***Zip:*** _____

Evening Phone #: _____ ***Daytime Phone #:*** _____

Work / Occupation or School / Grade

Worksites / School: _____

Occupations / Grade: _____

Travel History

1st ***Destination:*** _____ ***Depart Date:*** _____ ***Return Date:*** _____

2nd ***Destination:*** _____ ***Depart Date:*** _____ ***Return Date:*** _____

3rd ***Destination:*** _____ ***Depart Date:*** _____ ***Return Date:*** _____

4th ***Destination:*** _____ ***Depart Date:*** _____ ***Return Date:*** _____

Reporting Source

Title: _____ *Last Name:* _____ *First Name:* _____

Facility: _____ *County:* _____

Street: _____ *City/State:* _____ *Zip:* _____

Phone #: _____ *E-mail:* _____

Primary or Attending Physician

Title: _____ *Last Name:* _____ *First Name:* _____

Facility: _____ *County:* _____

Street: _____ *City/State:* _____ *Zip:* _____

Phone #: _____ *E-mail:* _____

Hospital Information

Hospitalized: ☐Yes ☐No *Patient Status Date:* _____

Hospital Name: _____ *Hospital City:* _____

Date Hospitalized: _____ *Number of Days Hospitalized:* _____

Notes

Supplemental Laboratory Report Form

Lab Reports

Laboratory Name: _____ ***Lab Report Date:*** _____

Ordering Provider Name: _____ ***Phone:*** _____ ***Facility:*** _____

Specimen Accession Number: _____ ***Specimen Collection Date:*** _____

Organism Name: _____ ***Organism Species:*** _____

Organism Serogroup: _____ ***Organism Serotype:*** _____

PFGE Results

Pattern 1 ***KS:*** _____ ***Other State:*** _____ ***CDC:*** _____

Pattern 2 ***KS:*** _____ ***Other State:*** _____ ***CDC:*** _____

Pattern 3 ***KS:*** _____ ***Other State:*** _____ ***CDC:*** _____

Additional Results Information

Reported Test Name:	*Coded Result:*	*Text Result:*	*Numeric Result:*	*Comments:*

Supplemental Contact Form

Contacts

Last: _____ ***First:*** _____ ***Middle:*** _____

Street: _____ ***City/State:*** _____ ***Zip:*** _____

Evening Phone #: _____ ***Daytime Phone #:*** _____ ***E-mail:*** _____

Sex: ☐Failure to Report ☐Female ☐Male ☐Other ☐Transexual ☐Unknown

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Unknown

Hispanic / Latino Ethnicity: ☐Yes ☐No

Date of Birth: _____ ***Age:*** _____ ***Age Unit:*** ☐Days ☐Weeks ☐Months ☐Years

Worksites / School: _____

Occupations / Grade: _____

Exposure Information

Contact Type: ☐Household ☐Sexual ☐Other: _____ ***Partner / Cluster Code:*** _____

Date of First Exposure: _____ ***Date of Last Exposure:*** _____ ***Frequency:*** _____

Nature of Exposure: _____ ***Comments:*** _____

Testing and Treatment Information

Clinic Code: _____ ***Examination Date:*** _____

Examination Test: _____ ***Examination Result:*** _____

Prophylaxis/empiric treatment date: _____ ***Drug / Dosage:*** _____

Provider (Name / Facility): _____

Disposition and Diagnosis Information

Initiation Date: _____ ***Disposition Date:*** _____ ***Disposition:*** _____

Diagnosis: _____ ***Referral Type:*** ☐Patient ☐Provider ***Post-test Counseled :*** ☐Yes ☐No

Currently Assigned To: _____ ***Follow-up Date:*** _____

Risk Factors

Pregnant: ☐Yes ☐No ***If Yes, # of Weeks:*** _____

Risk factors for complications in contact: ☐None ☐Pregnant Woman ☐HIV Seropositive ☐Unimmunized ☐Index case is a super-spreader

☐Child younger than 5 ☐Age > 65 ☐Otherwise immunosuppressed (s/p transplant, high dose steroids, etc)